



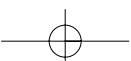
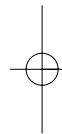
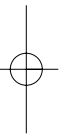
Government Response to the House of Commons Health Committee Report on the Provision of Allergy Services

Sixth Report of Session 2003–04

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
January 2005

Cm 6433

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Government Response to the House of Commons Health Committee Report on the Provision of Allergy Services

Introduction

This Command Paper sets out the Government's response to the Health Committee's Report on the Provision of Allergy Services. The Government welcomes the Committee's Report as a valuable opportunity to consider the future direction and scope of the services that will be needed to prevent and treat allergies, within the framework of action to improve care for long-term conditions. The Department of Health will ensure that the Committee's Report and this response are drawn to the attention of key stakeholders within Government, the NHS, the voluntary sector and beyond.

The Department of Health is committed to ensuring that the NHS develops as a service which offers high quality and personalised care to all its patients. The way to achieve this aim is to allow local healthcare bodies the maximum amount of freedom to plan and develop local services, within a broad strategic framework of standards set out by the Department. The Department's programme for change "Shifting the Balance of Power" rightly allows Primary Care Trusts (PCTs) to take responsibility for establishing the healthcare needs of their local populations and meeting those needs – including the need for allergy services – under the direction of Strategic Health Authorities (SHAs). This principle of empowering frontline staff and healthcare bodies underpins the Government's response to the Committee's report.

People with allergies can expect to receive care from a range of health and other professionals in conjunction with taking responsibility for managing their own condition. The Department of Health will therefore need to work with a wide range of key players to ensure future developments in allergy care are credible and command the respect and ownership of those people they are designed to help and the practitioners who care for them. The Department will consider the best way of involving these stakeholders.

The first key stage of this work will be to carry out a review of the available data and research on the epidemiology of allergic conditions, the demand for and provision of treatment and the effectiveness of relevant interventions. Developing a sound evidence base will be essential to determining the correct future direction for allergy services.

It will then be possible to develop the scope of future opportunities for action, which could include:

- The development of service models for managing allergy in primary and secondary care;
- Working with training providers to encourage the development of training in allergy;
- Encouraging national and local workforce planners to develop an appropriate allergy workforce, within existing wider plans to modernise the NHS workforce and underpinning plurality of provision;
- Developing a commissioning action plan which will encourage PCTs to take account of identified best practice and to build an integrated approach to the commissioning of allergy services.

Response to Recommendations

- 1. We believe that primary care should be the frontline provider of allergy care, but the skill base from which to build an adequate primary care service is lacking. In order to develop an appropriate primary care service, an infrastructure of specialist allergy services is therefore first required. As we propose below, it is imperative that specialist clinics for the treatment of allergy should be developed across the country, so that these can become centres of local networks of competent practice in allergy care, and facilitate the training and professional development of staff in primary care. It will, however, take several years for these centres to be fully operational. So we recommend below a number of measures intended to have a more immediate effect on the capacity of primary care to deal with the growing problem of allergy in the population. (Paragraph 49)**

Primary care currently plays a crucial role in the identification, treatment and referral of patients with allergies, and this should continue in the future. At the same time, we are keen to ensure that improvements are made to the current provision of more specialised services for allergy sufferers. The research proposals outlined in the introduction, the development of service models based on that research and the freedom of PCTs to respond to local need are, in the Government's view, a better basis for addressing this issue.

- 2. We believe a national primary care allergy network should be created to support those working in primary care to allow them to access second opinions, to offer peer review of services and to provide ongoing education and professional development. The active involvement of current and developing specialist centres is crucial to the existence of such a network. We recommend that the Department takes steps to draw to the attention of GPs the directory of allergy services produced by the British Society for Allergy and Clinical Immunology. (Paragraph 50)**

Primary Care Trusts and individual practitioners are already able to draw on a range of services and sources of information to improve the services they give to patients, as well as to ensure that patients who need specialised services are appropriately referred. However, it is always helpful to ensure that examples of good practice are widely available. It may therefore be useful for Strategic Health Authorities and PCTs to consider how local best practice in the identification and treatment of allergies could be made more widely available, and we will encourage SHAs and PCTs to consider how this could be done.

In addition the Royal College of General Practitioners (RCGP) has already undertaken valuable work through their Clinical Network Framework to ensure that their members are aware of current best practice. We will encourage the RCGP to establish guidelines on good practice in allergy identification, treatment and referral criteria.

The Department of Health will draw GPs' attention to the British Society for Allergy and Clinical Immunology's Directory of Allergy Services. We will achieve this using the "GP Bulletin", which is a Department of Health publication distributed to all GPs 11 times a year.

3. We recommend that in its next review of the clinical incentives in the current GP contract, the Department should introduce clinical quality markers for allergy. (Paragraph 51)

The Department of Health has always recognised that the Quality and Outcomes Framework (QOF) which underpins the GP Contract should not remain static. It will be reviewed by an independent expert review panel over the next 12-18 months, with the first substantive changes being made from April 2006. The NHS Employers Organisation, which is supporting the review panel, will in the New Year publicise details of how organisations, GPs and other interested parties can make submissions to the review. In drawing up potential indicators, it is important that they remain evidence or consensus-based and draw on robust and consistent data that is readily available.

4. Primary Care Trusts should consider how to ensure that people with allergy in their area know who is appropriately trained and who is clinically accountable for providing a service. We recommend that a named person in each PCT should be identified. This process should be overseen by Strategic Health Authorities as a regional overview will be important. (Paragraph 52)

People with allergies are likely to come into contact with a range of practitioners in the community, including GPs, nurses, pharmacists, midwives, health visitors and others. We agree with the Committee that these practitioners should be aware of the options available for referral, both within their local community and beyond. We will encourage SHAs and PCTs to ensure that information on allergy services is made widely available to practitioners.

We also recognise the key role that self-care plays in the management of allergies. Since 2002 the NHS-led Expert Patients Programme has offered opportunities to people with long-term conditions to learn new skills to help them manage their condition and improve their quality of life. By 2008 the Expert Patient Programme will be rolled out throughout the NHS and people with allergies should be encouraged to attend a course to enable them to manage their life well, including living with an allergy.

We will work with PCTs, GPs and Practice Nurses to ensure that people with allergies are aware of Expert Patient Programme courses. In addition, from 2006, NHS accredited health trainers will be giving support to people who want it in the areas of highest need, and from 2007 progressively across the country.

In addition the Food Standards Agency, together with the Department of Health, has produced a guide for those recently diagnosed with food allergy or food intolerance to give them information on how to avoid the foods to which they react, when shopping or eating out.

5. We recommend that the basic training curriculum for GPs should be reviewed, and modified as required, to take account of the need to have allergy as a basic component in the initial training for general practice. (Paragraph 53)

The content of the basic training for general practice is determined by the Joint Committee on Postgraduate Training for General Practice under the NHS (Vocational Training for General Medical Practice) Regulations 1997. We will ask the Joint Committee to examine whether greater prominence could be given to training in allergies.

6. We recommend that the Department should disseminate information to all PCTs on training provision in their area. Given the general level of ignorance of allergy in primary care we recommend the Department should provide some financial support to provide access to initial in-service training for a wide range of health professionals. We recommend that the Department assesses the quality of the various training courses on offer to GPs. (Paragraph 55)

People with allergies' first point of contact with the NHS is likely to be via primary care and many sufferers will not need any further or more specialised care. Primary care practitioners are able to use their knowledge, training and skills to provide high quality identification and treatment services, as well as advice and information on self care.

The Department of Health has no remit to review the content or quality of training courses in allergy. The Department will, however, encourage the regulatory bodies who do have responsibility for this issue – such as the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society – to review both the content of the courses currently on offer and the locations at which they are offered.

- 7. We conclude that, while GPs with Special Interest could make an important contribution to service development in allergy care, a precondition of their successful introduction is the prior availability of specialist care to underpin standards and provide clinical training and case management guidance. Nevertheless, the curriculum for GPwSIs could be developed with allergy consultants now, and we recommend that this should be done. The pace of change can then be set taking account of the overall programme required to modernise allergy care within the NHS. (Paragraph 62)**

The development of practitioners with a special interest in allergy (PwSIs) could ensure that some patients suffering from more serious and complex allergies are able to receive high quality care and treatment within their local community. However we do not believe that the successful development of PwSI services for allergies is dependent on prior changes to specialised allergy care. Instead we believe that expertise already exists within the NHS and beyond to enable the development of PwSIs for allergy services.

- 8. We recommend that the GPwSI National Development Team begin work on a framework for GPwSIs in allergy services, working with the current specialist allergy centres (and with additional regional centres once these are established) to identify the core activities of an allergy GPwSI, and the qualifications and/or experience that would make a GP eligible for such a position. (Paragraph 63)**

The Department of Health and key stakeholders such as the Royal College of General Practitioners have drawn up frameworks to allow for the local development of PwSI services. These frameworks include a generic framework for the development of a PwSI service, plus some tailored guidelines on key services such as drug misuse and mental health. For specialties not already included in tailored guidelines – which includes allergies – existing frameworks and supporting documentation provide a step-by-step guide to developing a framework and setting up a service. PCTs are expected to develop new frameworks in partnership with local clinicians, professionals and other relevant bodies, such as the Royal Colleges, according to local need. New frameworks are then made nationally available on the GPwSI website.

- 9. To show that it is genuinely committed to this planning phase, the Department should indicate that it wishes to see (and is prepared to finance) the creation of a first generation of GPwSIs in allergy on a sufficient scale to ensure there is a GP with a special allergy interest in each PCT, once sufficient consultants in allergy are available to train them. (Paragraph 64)**

PCTs have responsibility for determining the need for local healthcare services and for meeting this need, and they receive funding from the Department of Health to enable them to fulfil these responsibilities. PCTs are best placed to determine whether the needs of their local community would be best met by commissioning services from PwSIs, and for providing training and accreditation for those practitioners who may wish to specialise.

However PwSIs are not the only solution and PCTs will consider a range of options when developing any new service. Under the new primary care contracting arrangements a range of mechanisms have been put in place and these enable PCTs to develop the most appropriate service for their population. From April 2005 this will include Practice Based Commissioning bringing service development even closer to the patient.

10. It seems to us to be manifestly inequitable that there is no comprehensive allergy service in England north of Manchester or west of Bournemouth. The current provision in fact owes nothing to the geographical spread of allergy in the population. Rather, it comprises those centres where specialist research in allergy has taken place, on the back of which clinical services have developed ad hoc. (Paragraph 84)

The key issue is to ensure that services are provided to meet the need identified in any area. To facilitate the planning of services more extensive information is needed about the incidence of various types of allergy among various groups in the population and in different areas as well as the most effective methods of preventing and treating these allergies.

The first step to improving allergy services is to review the available data and research on the epidemiology of allergic conditions, the demand for and provision of treatment and the effectiveness of relevant interventions. This review will provide the Department of Health and the NHS with valuable information to use to begin to improve allergy services.

11. We endorse the proposal of the Royal College of Physicians that a minimum of one specialist allergy centre should be established in areas equivalent to each of the former NHS regions, serving populations of five to seven million, to offer at least some local expertise for allergy sufferers. More provision may well be needed in less densely populated areas. We also endorse their recommendations for staffing levels both for adult and paediatric care, that is to say that each centre should have as a minimum two adult allergy consultants, two paediatric allergy consultants supported by paediatric nurse specialists, two full-time nurse specialists, one half-time adult paediatrician and one half-time paediatric dietician. This is our key recommendation and the one on which all other elements to develop a national allergy service within the NHS will depend. (Paragraph 85)

We believe that improvements to allergy services should be firmly based on the best evidence available, and that more needs to be done to collect and review this evidence before decisions can be made about appropriate allergy services and their location and staffing. This is why we intend to carry out a review of the evidence. This review will give the NHS the information it needs to build an allergy service which is rooted in a very clear, agreed evidence base, which offers effective patient care and which is staffed by an appropriate workforce.

If the results of the review indicate that it is feasible and necessary, then one option for the future could be for SHAs, PCTs, service users and other key stakeholders in the healthcare and voluntary sectors to develop a number of service models to set out best practice in prevention and treatment services in primary and secondary care, as well as in other community locations such as schools and workplaces.

12. The specialist allergy clinics, other clinics capable of providing allergy services and hospital trusts need to develop new ways of working, or adapt old ways, to provide for a national network of interim care while a new cohort of allergists who will run these new centres is trained. Through these networks, the information could be gathered to locate new consultant allergist posts where unmet need is greatest as new doctors emerge from training. We believe that Strategic Health Authorities should play their part in co-ordinating such activity. (Paragraph 86)

SHAs and PCTs already have a responsibility for providing allergy services to their local community. The Department's review of the evidence on the epidemiology of allergy will provide information which they will be able to use to assist in determining the likely incidence of allergy in their local areas, and therefore the staff resources which may be necessary to provide high quality services to patients.

13. In the longer term, we would like to see allergy provided with a full specialist consultant workforce. The Royal College of Physicians' medical workforce projections indicate this would eventually require the creation of around 520 consultant allergist posts. This is clearly an ambitious goal and unachievable even in the medium term when starting from such a low base, even if the resources were available. We recommend that an important more intermediate target would be for most major teaching hospitals to have a consultant allergist-led service, covering adult and paediatric allergy, with appropriate support staff. (Paragraph 87)

The NHS Plan and the NHS Improvement Plan set out the NHS's commitments to undertaking a radical range of improvements to modernise the services it offers and to improve the care it gives to its patients. Developing the NHS workforce has been crucial in delivering the improvements we have seen to date, and it will be similarly crucial in continuing to offer modern, patient-centred services.

Workforce planning structures are designed to ensure that the NHS gears up to meet the demands of creating a modern health service which offers satisfying careers to staff as well as improved services to patients. We would expect any necessary development or expansion of the allergy workforce to be handled under these arrangements.

14. Childhood allergy presents problems which are in some respects identical, but in others distinct from those experienced by adults. What is most noticeable is that the gap between need and service performance is wider and growing faster in the case of paediatric allergy. We do not find it acceptable that children are being treated in adult settings and that there are only half a dozen consultant specialists in child allergy, given the prevalence of allergies amongst children. (Paragraph 100)

The Government agrees that adult treatment settings are not necessarily suitable for treating children. This is why the Department of Health and the Department for Education and Skills have recently published the National Service Framework for Children, Young People and Maternity Services. This ten-year programme is designed to bring about a fundamental change in the way services for children and families are organised, to ensure that they are built firmly around the needs of their users, and we believe that it will make a very real difference to the healthcare experiences of children and their parents. The National Service Framework for Children, Young People and Maternity Services should ensure that children with allergies are not treated in adult services.

The National Service Framework will be supported by a number of "exemplars" which are designed to stimulate professionals and patients to consider ways to deliver better services. One of the first of these exemplars concerns asthma, reflecting the recent rise in incidence of asthma among children. This exemplar describes a child's "asthma journey" and describes how a range of services and practitioners can work together with the child and his parents to manage his asthma as he grows to adulthood. Specifically, it describes how specialist allergy services can be used to determine the role, if any, played by allergy in the cause and management of asthma. We expect that this exemplar will provide the NHS and others with a valuable tool to develop child-centred asthma treatment and management services which take account of the need to consider allergy as part of an overall programme of care.

15. We endorse the suggestion of the Royal College of Paediatrics and Child Health and the Royal College of Physicians that there should be a parallel development of paediatric allergy services to those for adults, with the creation of regional centres, each staffed with a minimum of two paediatric allergists and support staff. (Paragraph 101)

The review of the available data and research on the epidemiology of allergic conditions, the demand for and provision of treatment and the effectiveness of relevant interventions, will cover paediatric allergy as well as adult allergy.

16. It should be recognised that with a specialist allergy service linked to a community paediatric team, help and support for school staff can be offered and children at risk of anaphylaxis can be managed. The creation of regional, specialist paediatric centres across the country, making expertise available to the schools through community paediatric teams, is the key to giving school staff the confidence that this can be done. This should be implemented as a matter of urgency. (Paragraph 107)

The National Service Framework for Children, Young People and Maternity Services does not just cover the provision of health services by health professionals working within the NHS, it also covers other practitioners who work with children and their families. The NSF makes it clear that a child and their family should expect to receive services which acknowledge the "whole" child and practitioners should work together to deliver these holistic services. As far as children with complex allergies are concerned, the NSF should help to ensure that school staff are equipped with the skills to deal with any issues or emergencies which might arise among their pupils.

17. We recommend that until a regional paediatric service can be established all local education authorities and schools should be guided by the *Supporting Children with Medical Needs: a good practice guide* and Anaphylaxis Campaign guidance. In addition, Strategic Health Authorities should ensure that community paediatricians liaise with the major allergy centres for advice on management of at risk children in schools until they have a consultant paediatric allergist in their region. (Paragraph 108)

The Government will encourage SHAs to seek advice from specialist allergy centres on the management of allergies in schools, and we will encourage schools to use the valuable guidance on managing allergy produced by the Anaphylaxis Campaign.

18. We are concerned that the current arrangements for inspection of the independent sector by the Healthcare Commission only cover facilities providing medical treatment. Evidence submitted to our inquiry has illustrated that the use of expensive, and often useless tests, creates considerable unnecessary expense and worry for patients and also may place them at risk. We therefore recommend that the Healthcare Commission should be required to inspect organisations providing diagnostic services in allergy, as well as those offering treatment. (Paragraph 118)

Since 1 April 2004 the Healthcare Commission has been responsible for providing an independent assessment of the standards of healthcare services received by patients. It assesses treatment services provided by the NHS, private and voluntary sectors. In the short time that it has been in operation the Commission has begun to make a real difference to the quality of care patients receive.

The Commission's functions and responsibilities are set out in the Health and Social Care (Community Health and Standards) Act 2003. The Department and the Commission will be keeping these functions under review to make sure that the Commission can fulfil its objectives of ensuring quality and value for money in the provision of healthcare. As part of this work we will consider whether the Commission should have any role with regard to the provision of allergy diagnostic tests in the independent sector.

All pathology laboratories in the NHS are now required to enrol with a relevant laboratory accreditation scheme. We suggest it would be good practice for laboratories in the independent sector offering allergy testing also to participate in relevant accreditation schemes.

19. We recommend that the Department should ensure that the National Code to record allergy services is implemented comprehensively and effectively and that, as the NHS moves allergy care more towards its mainstream, there should be an adequate investment in clinical and operational research into allergy, so that understanding can grow across the service about what this area of care can offer. It is vital that the Department obtains an accurate map of where allergy services are actually being provided so that it can more effectively secure equitable provision, and more realistically gauge current demand on services. (Paragraph 134)

The Government accepts that more information is needed on the effectiveness of allergy interventions and where they could and should be offered. The review of the epidemiology of allergies, demand for and provision of treatment and the effectiveness of relevant interventions, described at paragraph 10 above, will also cover operational research and will determine whereabouts allergy services are currently offered. This will help PCTs to ensure that they are offering the right services in the right locations.

The National Code provides for new treatment function codes including a code for allergy treatment, and these new specialty codes are now available for use. While the Department of Health can continue to encourage the submission of good quality data on patient care, there must be local discretion on the use of appropriate treatment functions such as the National Code to record allergy treatment.

20. Overall, we do not accept Dr Ladyman's thesis that the apparent lack of excessive demand for services indicates that there is no convincing evidence of unmet need. It is not possible for doctors to refer patients to services where none are available. Further, there is no mechanism to measure this unmet need. Patients themselves will often not be aware of specialist services and are often in any case not properly diagnosed. The accounts we have received from hundreds of patients demonstrate the frustration felt by individuals over the difficulties in securing appropriate treatment, and over the lengthy waits and long journeys they are experiencing. The NHS is currently not a national service as far as allergy care is concerned. And even when there is an allergy clinic within reasonable travelling distance, the expressed opinion of the Department appears to be that patients for the most part should be seen elsewhere before a select few are referred on to an allergy specialist. Passing individuals around the system in a way driven by the scarcity of appropriate care is not right. And indeed, as we have noted above, for patients in many parts of the country even being passed on is not a viable possibility without excessively long journey times. It is clear to us that there is a large and growing gap between need and appropriate allergy care within the NHS. (Paragraph 135)

The review of the available data and research on the epidemiology of allergic conditions, the demand for and provision of treatment and the effectiveness of relevant interventions will provide additional information on the need for allergy treatment and management in primary and secondary care. It will also give SHAs and PCTs a valuable tool to support them in planning and delivering allergy treatment services.

Nevertheless the Government believes it is right that people who suffer from certain conditions, particularly asthma and dermatitis, should be treated in the first instance by a health professional who specialises in these conditions. Consultants in respiratory medicine and dermatology are best placed to identify the cause of the condition and the best way it can be treated and managed. These specialists will be able to determine the role – if any – that allergy could play in the condition, and will be able to refer those patients on to specialised allergy services. A service model which sends all patients with certain conditions where allergy can sometimes be a contributory factor to specialised allergy services would substantially increase the false-positive referral rate. This service model would not make the best use of the skills of staff in specialised allergy services. It would also not offer patients the high quality personalised care they should expect from the NHS and at worst, it could mean a potentially serious delay in receiving the correct treatment for their condition.

21. Given the serious inequality of access to specialist allergy services, the key role which regional centres would play in turning matters around and the absence of active allergy commissioning locally across the NHS, we believe that there would be merit in the National Specialist Commissioning Advisory Group treating the specialist allergy services as national services, and thus eligible for specific NHS funding. To do this would be to take a first step in the proactive commissioning of allergy services. (Paragraph 155)

The National Specialist Commissioning Advisory Group was set up in 1996 to provide advice to Ministers on commissioning services for conditions which are rare and expensive to treat. National commissioning of services for these rare conditions is essential to ensuring that services are offered to patients who need them and that clinical expertise is built up and maintained.

The National Specialist Commissioning Advisory Group undertake the commissioning of those services where the expected national caseload is around 400 cases per year, up to a maximum of 1,000 cases per year. The Committee's report notes that the incidence of allergies needing specialised treatment could be expected to exceed the 1,000 case threshold. It would not therefore be appropriate to involve the National Specialist Commissioning Advisory Group in the national commissioning of specialised allergy services.

22. We further believe that the underlying problem of how to stimulate and inform local PCT commissioners needs also to be addressed. Fortunately, the Minister has already suggested a way forward to begin to do this. We welcome the Minister's suggestion that he should ask the Chief Medical Officer to prepare an action plan and we look forward to its publication which we hope will take account of the conclusions of our report. (Paragraph 156)

The NHS is a locally focused service and it is for PCTs, managed by SHAs, to commission and deliver the vast majority of healthcare services for their local communities.

The Chief Medical Officer will lead work to identify possible further work to develop a full range of allergy services. In doing so he will take account of the evidence review we will commission, the views of other stakeholders and the Committee's report.

23. We are strongly of the view that the Department should use its ability to invest in the training of specialist allergy doctors in order to initiate the changes required to bring about a modern allergy service within the NHS. This is the key step in making progress. It is a clear national responsibility to ensure that the NHS has an adequate medical workforce. Investment through the strengthening of the workforce is an economic and cost-effective way of moving towards a national service for allergy. (Paragraph 162)

We agree that allergy services should be delivered by an appropriate workforce. Local and national workforce planning systems already exist to ensure that an adequate workforce can be developed, including the creation of additional training posts.

24. The Department has been advised what would be needed both to maintain the existing specialist workforce numbers and to take the first steps towards creating the basis of a national service. Training provision for adult allergy should be increased with an additional 10 posts in 2005 and a further 10 in 2006. A similar number of trainees is needed in paediatric allergy. We believe this would be appropriate and we make this the cornerstone of our proposals for responding to the allergy epidemic. (Paragraph 163)

The review of the available data and research on the epidemiology of allergic conditions, the demand for and provision of allergy treatment and the effectiveness of relevant interventions will include work to establish the location of current allergy treatment services. This will provide the NHS with the data to estimate the staff required and the skills they will need to have in order to meet need in the population.

25. We also recommend a parallel initiative to develop the slightly different training arrangements for paediatric allergy to bring it up to a state of readiness comparable with that of adult care. Ten paediatric training posts should be earmarked for allergy for 2005 and a further 10 for 2008. In addition, in paediatrics, training in allergy is currently combined with training in immunology and infectious diseases. It is our view that allergy should be a separate disease sub-specialty in the paediatric training curriculum. (Paragraph 164)

As above, the Department of Health and the NHS will take work forward on determining need and the NHS will use that information to develop the allergy workforce. The Committee also recommends that training in paediatric allergy is separated from treatment on immunology, and the Department of Health will draw the attention of paediatric training providers to this element of the Committee's conclusions.

26. As part of the commitment to develop regional allergy centres as the first crucial step towards a national NHS allergy service, the Department should endorse and underwrite the creation of additional consultant allergists posts (at least two adult and two paediatric) in every region (as defined in paragraph 85) into which these trainees could move. (Paragraph 166)

We have set out our plans for enabling the NHS to assess the allergy workforce. However in this conclusion the Committee also touch on the creation of a national NHS allergy service.

The management of allergies needs to be seen as a mainstream healthcare issue, and one which will be of relevance to a range of practitioners throughout the NHS. This points firmly to the retention of PCT responsibility for the commissioning and delivery of allergy care, including the creation of any additional staff posts.

27. In total this would amount to an investment by the Department of 20 new allergist doctors beginning in 2005 and a further 20 in 2006-08, covering both adult and paediatric allergy care. This level of investment in training could, we believe, be absorbed within the existing training infrastructure for allergy doctors. Subsequent investment in the future through the employment of these doctors needs also to be assured. We call on the Department to use the means at its disposal to do this. (Paragraph 167)

As outlined above, arrangements exist to enable national and local workforce planners to assess the need for allergy consultants and options for meeting this need. The local NHS has the option to create additional Specialist Registrar training posts where it feels they are needed.

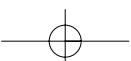
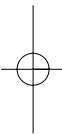
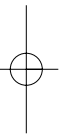
However, Specialist Registrar posts are only a small part of the workforce picture. The funding for the vast majority of health service posts is drawn from the budgets of Primary Care Trusts, reflecting their key role in planning and delivering services. We would therefore expect Primary Care Trusts to make decisions on the funding and location of any necessary additional staff specialising in allergy.

28. Overall we believe a long-term commitment by the Department to build a modern national allergy service would be the appropriate response to the current situation. Achieving this aim is clearly a long-term endeavour starting from the current very low base of provision. But the problems are not going to go away; indeed, they will increase, given trends in disease prevalence. So we believe a start must be made now. It is important not to fragment the use of scarce resources, so we believe leadership around an integrated strategy is vital, and call on the Department to produce a strategy statement indicating how it proposes to develop allergy services, taking account of all the proposals in the RCP document, as well as those contained in our report. The first essential element needs to be the creation of regional specialist centres to lead and to underpin service development across the whole country and to secure the resources for these in ways that will give everybody confidence in their continued existence in the NHS. But change needs to go beyond this. It needs to be sustainable within the devolved processes for the modern service. It may be that, as happened with cancer services, an individual, or small group of individuals, could be assigned a specific role to drive through policy change, and provide the millions of allergy sufferers with the appropriate provision for their condition, a provision which is currently largely absent from the NHS. We would like to see proposals from the Department which will bring allergy services into the mainstream of NHS care and a mechanism to ensure their implementation. (Paragraph 169)

It is vital that the action to improve allergy services should have the support of all the many practitioners and organisations involved in providing care to people with allergies, as well as allergy sufferers themselves. The Department of Health and the NHS will therefore need to work not only with practitioners who currently specialise in allergies, but also with specialists in other key areas such as immunology, respiratory disease, dermatology and nutrition as well as with GPs, with community nurses and health visitors, with schools and with patients themselves.

This response sets out the key steps the Government will take to improve allergy services. The first step will be to assess the scale and nature of the issue that needs to be addressed and to ensure that there is a robust, agreed base of information from which to move forward. The Department of Health will therefore carry out a review of the available data and research on the epidemiology of allergic conditions, the demand for and provision of treatment and the effectiveness of relevant interventions.

The results of this review will provide a basis for any further action it may be necessary to take to continue to provide high quality allergy care.





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